Women are twice as likely to start a business as men, and we must encourage that and ensure that a level playing field is available to women for access to capital and information. In 1995, as a small business owner, I was a delegate to the White House Conference on Small Business where many of these issues were discussed. Now, as a Member of Congress, I have not forgotten the issues that we discussed then and I believe that we need to bring them again to the forefront.

I would like to take a moment to acknowledge the many women who fought so hard for the right of women to achieve economic self-sufficiency. Let us carry on that tradition by honoring the millions of women business owners today and by supporting the millions of business owners we have to come.

REPORT ON RESOLUTION PROVIDING FOR CONSIDERATION OF H.R. 992, TUCKER ACT SHUFFLE RELIEF ACT

Mr. HASTINGS of Washington, from the Committee on Rules, submitted a privileged report (Rept. No. 105–430) on the resolution (H. Res. 382) providing for consideration of the bill (H.R. 992) to end the Tucker Act shuffle, which was referred to the House Calendar and ordered to be printed.

REPORT ON RESOLUTION PROVIDING FOR CONSIDERATION OF H.R. 1432, AFRICA GROWTH AND OPPORTUNITY ACT

Mr. HASTINGS of Washington, from the Committee on Rules, submitted a privileged report (Rept. No. 105–431) on the resolution (H. Res. 383) providing for the consideration of the bill (H.R. 1432) to authorize a new trade and investment policy for sub-Saharan Africa, which was referred to the House Calendar and ordered to be printed.

REPUBLICAN LEADERSHIP NEEDS TO ACT NOW ON BASIC PATIENT PROTECTIONS

The SPEAKER pro tempore (Mr. JENKINS). Under the Speaker's announced policy of January 7, 1997, the gentleman from New Jersey (Mr. PALLONE) is recognized for 60 minutes as the designee of the minority leader.

Mr. PALLONE. Mr. Speaker, this evening I would like to discuss an issue which I have addressed on the floor of the House many times before and probably will deal with a lot more as we move through the session in this year, 1998; and that is the need for managed care reform.

I believe that the American people have the best health care in the world. Unfortunately, the quality of care is being limited by HMOs or managed care plans. I think that Congress must act now to enact basic patient protections, but to put the ''care'' back in managed care.

Many of us have talked for the last year or so about the types of things that should be included in an effort to reform managed care. The President had an advisory committee that issued a report that went through various patient protections that could be included. At the same time, in his State of the Union address the President talked about the need for patient protections and basically called upon the Congress on a bipartisan basis to pass managed care reform. I have actually introduced a bill, a number of our colleagues have introduced legislation that would put patient protections in effect in the context of managed care organizations.

But what has not happened and what needs to happen is that this House and this Congress must pass legislation and should get to doing so as quickly as possible. The time for talk is over. The time for action is now. We do not have a lot of time left because of a shortened legislative calendar in 1998, and I think we need to move in committee, we need to move on the floor and we need to move in both Houses towards managed care reform.

I have to say that I believe very strongly from every indication that I have received that the Republican leadership is not interested in moving forward on managed care reform. There has been a tremendous amount of money coming from special interest groups, from the insurance companies, in particular, that have been lobbying Members of Congress not to pass a managed care reform or patient protection act legislation in this session of Congress.

The Republican leadership has been out there saying that they do not want to do it, and I think what we have to do as Democrats and those Republicans that are willing to join us, is to push the Republican leadership. Because they are in the majority, we have to push them to bring this legislation through committee to the floor so that the President can sign it.

I have to say that this is a very important issue for our constituents. Every time I go back home and hold a town meeting, constituents ask me when Congress is going to provide common-sense managed care reform.

In New Jersey, the voters spoke loud and clear and the State legislature, along with Governor Whitman, a Republican, enacted model patient protections. It was not radical legislation in New Jersey. It has not substantially increased costs as the special interest lobbyists would have us believe. Instead, it was principled on choice, access and quality health care.

Let me just give my colleagues an idea, if I could, about the types of things that we are talking about when we talk about a Democratic managed care reform initiative.

Basically what we are saying is that individuals enrolled in managed care plans would be guaranteed that their health plan will have enough doctors and health providers in its network to ensure that they get the care they need on a timely basis, that they would have the right to choose to see providers outside their health plan, that they would have the right to see specialists when necessary outside their health plan, that they would be guaranteed that their doctor would be allowed to tell them about all their treatment options, that is, no plan would be able to use gag rules to restrict doctors' communications with patients, that they would have access to emergency care without prior authorization in any situation that a prudent lay person would regard as an emergency.

For women with breast cancer, they would be allowed to stay in the hospital following surgery for a minimum of 48 hours for a mastectomy, or 24 hours for a lymph node dissection. For a women to be guaranteed the right to direct access to their obstetrician-gynecologist and be able to choose their obstetrician-gynecologist as their primary care physician.

When a service and procedure is covered by their plan, that they be guaranteed that they and their doctor, not the insurance bureaucrats, would decide what care is medically necessary for their treatment, that they be able to get authorization for care from their plan in a timely manner based on clear, objective written guidelines, that they be guaranteed that if they were denied care by their plan, there would be a timely, reasonable and meaningful system of recourse for those with life-threatening illnesses allowing them to participate in a clinical trial for experimental therapies at no extra cost to them, that they have protections against discrimination on the basis of health status, genetic information and other factors, that for women who have had a mastectomy, guaranteed coverage for reconstructive breast surgery, that they have access to medically necessary drugs, that they be guaranteed that their health plan does not use discriminatory practices when choosing doctors or other health providers who participate in its network, that they be guaranteed that their health plan would be subject to these new protections regardless of whether it is licensed at the State or Federal level and that they be provided full, relevant information about their plan, including which benefits are covered and which are excluded, what the individual costs are, what the plan policies are regarding authorization and denial of care and what their plan's policies are regarding selection and payment of providers.

Mr. Speaker, these are a few of the common-sense provisions that the American people want enacted. New Jerseyans in my State are fortunate to have a responsive State legislature that addressed these issues but unfortunately not all in New Jerseyans will be able to enjoy the same level of patient protections. That is because the

Employee Retirement Income Security Act of 1974, ERISA, says that State laws do not apply to companies that self-insure. This means that many of the constituents of my State are left without adequate health care quality standards.

In a sense there is a two-tiered standard in my State and in many others. Only Congress can act to address this shortfall. ERISA comes under Federal law.

The Democrats are gearing up to fight for the rest of the American public's right to common-sense, quality health care. We understand that it is good that State legislatures passed these individual laws in their State, but it does not apply to a lot of people who are self-insured. It also obviously does not apply from one State to the other. That is why we need Federal action.

I am pleading with the Republican leadership not to sit on the sidelines. They have to basically realize that regardless of what the special interests say, this is the type of legislation that the American public wants, that the American public needs, and that we should be addressing here during our debate this year in 1998.

One of the things that I noticed, Mr. Speaker, is that when we have forums back in my district in New Jersey, and we have had some and we are going to have a lot more on the issue of managed care reform, that many people will show up and basically tell the story, if you will, about their individual problems that they have had, or their children have had or their mothers, their fathers have had, or friends with managed care plans that have denied them coverage or denied them certain services, and how difficult it has been for them to appeal with the denial of certain coverage and to get through the bureaucratic process that many managed care plans necessitate when you try to get some service or some procedure that they deny or that they will not allow.

I could give my colleagues many examples of that, but I wanted to give one example tonight because this was a woman who came to our hearing that we held in January. Her name is Cheryl Bolinger. She in particular, I thought, explained very well the morass or the maze, if you will, that one has to go through when trying to get the managed care plan to approve a service or procedure that they do not want to approve.

I do not know if I am going to read the entire thing, because I know I am going to be joined by another Member here, but I wanted to at least start with some of the testimony that Ms. Bolinger gave at a hearing that I held, along with Senator TORRICELLI, back in January on the issue of managed care reform.

She said that she is the mother, Mrs. Cheryl Bolinger from New Jersey, of a 15-year-old child who has multiple developmental disabilities and complex chronic mental problems. Her daughter Kristin's medical problems began shortly after her birth. At 6 weeks of age, she developed unexplained intractable seizures. Because of the severity and the debilitating effects of her condition, she must be followed by many specialists and undergo many specialized and expensive diagnostic tests.

''Today, that was in January, Kristin remains nonverbal and nonambulatory and requires customized durable medical equipment for every aspect of daily living. Customized equipment is also needed to prevent and minimize the effects of orthopedic problems. She also requires physical and occupational therapy to enhance and maximize her potential in terms of her orthopedic status and general medical condition.

''During Kristin's infancy and early childhood we were fortunate enough to have a fee-for-service insurance plan. As long as our medical documentation was current and in place, in other words, prescriptions, follow-up care and letters of medical necessity, we did not encounter problems obtaining adequate and proper medical care regarding all areas of our daughter's acute and long-term care. In 1993, however, our insurance plan was changed to an HMO.''

This is something, Mr. Speaker, that of course has happened to many people who had a fee-for-service plan where they could choose their doctor and switched and were forced basically because their employer switched to an HMO.

Ms. Bolinger goes on to say that at that point, when she changed to the HMO, ''We encountered many difficulties regarding Kristin's medical care. According to the plan, we had to choose a pediatrician who had contracted with the HMO to serve as her primary care physician. The pediatrician who had been seeing Kristin for many years was not a participant in the plan. Likewise the specialists who had been treating her for so long also were not plan participants.

''My husband and I were very upset over this change and need to give up the excellent care Kristin had been receiving from these physicians. We were very concerned about the future of our child's health care. Nevertheless, we tried to be optimistic, and we visited a plan-approved pediatrician who would serve as Kristin's primary care physician. To our dismay and disappointment, we were not satisfied with the level and quality of care provided.

''Our freedom to choose a suitable physician for our child, while receiving adequate insurance coverage have been taken away by the HMO.''

If I could just stop here, Mr. Speaker, from Ms. Bolinger's statement before our hearing, this is, of course, the problem. Now that people who for many years had been taken care of by primary care physicians whom they knew and whom they respected and who they felt were doing a good job, now all of a sudden had to be replaced by someone within the HMO.

I think what I am going to do at this point is to stop here in talking about Ms. Bolinger's case, because I can go back to it later on, because I want to, if I can, give time to one of my colleagues from the Committee on Commerce, the gentleman from Texas (Mr. Green). He, I know, has been involved with this managed care issue for some time now and has had many experiences in his own district where people have come up to him and talked about some of the problems that they have had.

☐ 1900

Mr. GREEN. Mr. Speaker, I want to thank my colleague from New Jersey (Mr. PALLONE) for requesting this hour special order talking about managed care and patient protection. A lot of folks, though, and I found out in my own district in Houston, I represent a very urban district, we had a managed care town hall meeting not yesterday, but the week before, and just asked senior citizens, average working folks, we had physicians, providers, even some hospital representatives come talk about managed care.

What I found out is that first of all, for the discussion tonight, we need to make sure that people know that some States like New Jersey and Texas have passed legislation but that only covers insurance policies or HMOs that are licensed to practice in that State.

A great many employers come under what we call the ERISA Act. It is a Federal act that was passed in the early 1970s. Because so many of our employers are multi-State and sometimes multinational, an employer in Texas and New Jersey, obviously, they would not want to have to jump through both restrictions in each State, so Congress passed something that said, okay, you can come under Federal law for your health care, and so many of our constituents now come under Federal law.

So what is happening, though, is that we are lagging behind some of the innovative efforts that States are doing to provide for more patient protections. Both the bill of the gentleman from New Jersey (Mr. PALLONE), and of course the gentleman from Georgia (Mr. NORWOOD) has his bill that has over 200 cosponsors, and the gentleman from New Jersey (Mr. PALLONE) and I are members of the Democratic Health Care Task Force where we are working on legislation that will be similar on managed care reform, patient protection reform. The gentleman from Michigan (Mr. DINGELL), our ranking member on the Committee on Commerce, is putting that together and will be the lead sponsor on that.

We need to ensure that every American enrolled in an HMO or a PPO or a PSO, also known as managed care, gets first-rate health care with benefits and the quality and the protections that both they come to expect and that they also deserve. Americans should not be required to give up access to their quality health care just because we in

Congress are not doing our job in bringing the Federal law into the same realm that the private industry is doing.

The gentleman and I were both here in 1993 and 1994 when we heard the fear of government-run insurance. Well, we did not pass any of those bills and now we do not have government-restricted care, we have industry-run insurance. So we have seen the fear of 1994 and 1994 come to light, and in 1996, 1997 and 1998, because we are seeing restriction in choice, and it is not because the government is telling someone that they have to do it, it is because the market is doing that. Employers are trying to cut the cost for their bottom line, and I understand that and I am for that, but I also know that is what one can do, when we are seeing a cutting of the cost and also a cutting of the benefits and what people are assuming hopefully will be quality health care.

There are some great managed care networks in our country, and some of them are really good. What I would like is just to have, whether it be the Norwood bill or the Pallone bill or the Dingell bill, that would just give some guidance to managed care networks in our country so people will know what they can expect, that they have some flexibility; that, importantly, they should not lose control of the decisions regarding their personal health care.

Although I have to admit trends are bleak unless we pass legislation, the picture is limits on access, limits on information, and even limits on accountability. The trend is not acceptable and must be corrected by those of us who the people elect in Congress to deal with that.

An individual in my district, they do not have the ability to negotiate. Their employer often does, and I have even had employers who come up to me and say, ''I would like to have some guidance.'' Our concern is to provide the best care for our employees at the cheapest rate and the cheapest price. But there is bound to be a convergence of that, and I do not think we are seeing that, whether it be in my district or around the country.

It is time for the managed care companies, the insurance companies and the plans to be more accountable in delivering quality care and respecting basic human rights, consumer rights. By setting this standard and the guidelines, what we could have will be an effective tool for delivery of first-rate health care. But it also will give people, the consumer, the ability to know that when they go out on the market, whether it is as an employer or employee, they will also know some of the guidelines that each company that is bidding on their business would have to comply with.

Our health care task force and our full committee and our subcommittee, we have not had as many hearings as I would like to have, but our Democratic Health Care Task Force has adopted an agenda that will assure patients high-quality health care by requiring these HMOs or insurance companies or managed care plans to provide patients with access to specialists, coverage for emergency services which cannot be denied by the plan. I have heard it, and I have heard it from other Members of Congress, and I have had constituents who have gone to an emergency room because they had chest pains, and because they did not have time to preclear going to a different hospital than was on their plan, their plan will not pay for it because their chest pains turned out to not be a heart attack.

Well, the gentleman and I are not physicians and we are not the people, and neither are our constituents, that should diagnose their illnesses. They go immediately because we know with heart conditions, the quicker you get to health care, the better. So that is why it is important to have easy access to emergency services.

Also, internal and external appeals process, so if someone is watching who is making those decisions, that is what is important; and then confidentiality of medical records.

Mr. PALLONE. Mr. Speaker, if I could just interrupt my colleague for a second on that last point, when I was using this example of Ms. Bollinger as one of the people that has written to me and talked to me about the problem that she had with her child, one of the things that was most important to her was the last thing you mentioned about the grievance and appeal procedure. Because my colleague understands and I understand, but I think a lot of people do not, that if you are an individual like her that has a daughter that needs this kind of care that has been denied, it is very difficult, first of all, in that strenuous situation which she was in, to be calling up the bureaucrats and telling them this is what you want them to do, and getting the papers together and trying to find a means, if you will, to overturn a decision that they have made to deny the care. So if there is not some sort of expedited procedure that is easily accessed by someone to make an appeal or to express a grievance, they are not going to be able to succeed in changing the decision the insurance companies made.

So I just wanted to mention that, because even though it does not seem like it is very important, it is crucial to these people that are trying to get justice and make sure that the coverage is there.

Mr. GREEN. Again, it is just some guidance so people will know that if they make that call for pre-clearance, that if that decision is made that they have some appeal process, and that is just fair. I do not want to particularly go hire a lawyer to do it, I just want to have some process that that layperson can do.

The confidentiality of medical records, I know it is part of the President's plan; and also, with what we are concerned about with genetic privacy, we need to make sure that our medical records are as confidential as possible and yet still allow for research. But with what is happening in the National Institutes of Health and the discovery of genetic makeup of ourselves, we need to make sure that we protect individuals so that they are not excluded from health care because of their genetic makeup that they do not have anything to do with, because we are forcing them then onto the public system where all taxpayers have to pay.

In the patient participation in medical decisions, during our town hall meeting on health care about 8 days ago I had a hospital come in, it is Texas Children's Hospital in Houston, that is a secondary HMO, because they only deal with children, and they talked about the scenario that they are a recent HMO, they have only gotten in the business as a PSO or provider service organization.

But one of the things they want to do is sit down, and they are doing it with the parents and the children, so that the parents will know, and it is even more important with children, because as a parent we are concerned about what happens to our children, so we want to make sure that those decisions are made cooperatively and that we understand what is happening with our children. Like I said earlier, similar protections have been made in health insurance reform, like I said, in the State of Texas and also in New Jersey, but the State of Texas reform is being challenged by one of the insurance carriers. But the problem exists here on the Federal level. The States can only do so much, and we have to respond to our constituents.

I know I have a colleague from Texas (Ms. EDDIE BERNICE JOHNSON) who has a health care background, is a nurse, and I have had the honor of serving with the gentlewoman for 25 years, and I have always looked for her guidance with her health care background because I do not have any health care background. I was a printer and a lawyer and a business manager. So the gentlewoman has been able for many years as a State legislator and here in Congress to help bring us that perspective to us in Congress.

But that is why it is so important for us in Congress to respond, whether it is the Norwood bill, or Pallone bill, or Dingell bill. No matter what we do, we have to address the need for reform and the way health care and managed care and HMOs are delivered, and follow the lead of a lot of States that have tried to do this as best they can with the State insurance policies. We have to do it on a national basis.

Mr. PALLONE. Mr. Speaker, I appreciate the gentleman's remarks, and I just want to point out what the gentleman pointed out over and over again, that this is really pretty common sense. The things that the gentleman listed are things that we really should have in place on the Federal level. Even though it is true that the

gentleman's State and my State have adopted some patient protections, it does not help a lot of people, even in our own States, and certainly does not help anybody who is not in our States, and that is why we need Federal action.

Maybe tonight we can go through some of these patient protections in a little more detail and give some examples of how it might impact people, because I think as the public understands what we are talking about, they understand how simple and common sense these principles are and why they should be enacted into Federal law.

Ms. EDDIE BERNICE JOHNSON of Texas. Mr. Speaker, will the gentleman yield?

Mr. PALLONE. I yield to the gentlewoman from Texas.

Ms. EDDIE BERNICE JOHNSON of Texas. Mr. Speaker, I thank the gentleman.

There is real concern going on, because as we began to talk about the patient concerns, we began to see ads coming onto television to attempt to actually frighten people. I think that what we are attempting to do now makes a lot of sense.

As long as we have health care that is focusing on how much dollars the insurance companies can save and how much they make, and they make a lot of money, then we get away from patient basic needs. Clearly, we want every business, legitimate business to make money, but in health care when it is only focused on how much the insurance companies make, we tend to get away from basic human desires and needs. I believe we have gone too far, and I think that is one of the reasons why bipartisanly concerns now are being expressed here in the Congress.

We are seeing situations where patients are being taken away from the doctors they have had for 25 or 30 years, and they do not get an opportunity to get to know who the doctor is on that staff because they do not spend any time with them. The anxiety levels go up, and often the interventions, the contact the patients might have might increase instead of decrease.

We see a number of people in my district that are complaining about getting sick after 5 o'clock, or getting to the office of an HMO about a quarter to 5 and they close at 5 and they will not let them in, and if they are really sick they have to go to the emergency room, which costs twice as much as having a simple intervention. When patients have to give up physicians that know them individually and know their records, because no matter what the illness is, individual bodies react differently, and when they have had the same physician for a number of years and all of a sudden they have to give that physician up, it affects that patient negatively.

The complaints are so great that I do not know how we can address them without this legislation. When we talk about Patient's Bill of Rights, often nobody knows what we are talking about, but it is really a very simple thing to address the concerns that patients have now.

I suppose that one of the major concerns is the fact that they cannot choose their own physician, which often makes it so that they have to travel miles across town to get to where they need to go, and this is especially a problem in a large metropolitan area that I represent a major part of. When we have people that live 25 and 30 miles away from the nearest office of an HMO, and they are elderly and they are depending on public transportation, it makes it very difficult to get there. And if they work, it makes it almost impossible to get preventive care, which is primary care, which is the least expensive care, which is the most important to invest in, because once someone gets the information, learns how to take care of themselves, it reduces the health care bill because they do not have to go as often when they have that information.

☐ 1915

Mr. PALLONE. Mr. Speaker, if I could interrupt 1 minute, I think this issue of choice of doctors is so crucial to the whole emphasis that we as Democrats are putting on managed care reform. The President has talked about this, and, of course, as the gentleman from Texas (Mr. GREEN) mentioned, our health care task force, which is about to put out a bill that the gentleman from Michigan (Mr. DINGELL) is going to be the lead sponsor of, talks about patient choice.

I am not saying, and I do not think we can maybe say that, in a network, in an HMO network, that we have to guarantee in every case that we can choose any doctor we want.

Ms. EDDIE BERNICE JOHNSON of Texas. No. I do not think that makes sense.

Mr. PALLONE. But that maybe would break up the whole idea of managed care.

Ms. EDDIE BERNICE JOHNSON of Texas. That is right.

Mr. PALLONE. But at least people, when they initially choose a plan, should have a choice that, if they want a point of service option so they can go outside the network, they can.

That means they might have to pay a little more of a nominal fee; I do not have a problem with that. But there has to be some way so that people have the option of choosing a doctor if they are not satisfied with the doctor they have.

That is the problem I think that so many people bring to my attention now that they do not have that choice anymore. It has been denied them.

Ms. EDDIE BERNICE JOHNSON of Texas. Yes. It is clear that, if every person chose every doctor that they wanted or not wanted to move from any physician, it probably would interfere, clearly it would interfere with the concept of a health maintenance organization. However, there ought to be choices within that network. Personnel does not always click with personalities.

Often, physicians as skilled as they are, might have particular areas with which they show concern, and they are very interested in a particular area and might not be as interested in another area.

I think that patients ought to have a right to choose within that network what physician they see, because that patient/physician relationship has a lot to do with the progress of that patient. This is a new experience anyway for these patients, and just having that opportunity could make it a much more acceptable experience for them.

We recognize that the cost of health care soared. We understand that these interventions are for the purpose of controlling some of that cost. But when we have to give up all of the quality, it is not worth it. We have to maintain a level of quality that our patients can do well with. In order for them to do well, they absolutely have to have some choices. Not everyone can go to the hospital with the same diagnosis and get out in 3 days. It might take some 5.

Mr. PALLONE. If I could ask the gentlewoman from Texas to yield back to me, I think it is particularly important when the gentlewoman talks about access to specialists, because, oftentimes, the HMO, the network will not have the specialty care that is needed. And I think that there should be a guarantee.

One of the things we have talked about as part of this managed care reform, that if the plan, if a network does not have a specialist that is qualified or can handle that particular situation, that we should be able to go outside of the network to get the specialist. That is another complaint that I hear quite a bit about.

Ms. EDDIE BERNICE JOHNSON of Texas. That is correct. Clearly, that is why we have specialists, because certain physicians specialize in areas that are needed. We need the specialists. If patients do not have access to those specialists, then we are not offering them the greatest opportunity for recovery or for getting the best information that they can have, the best approaches for taking care of themselves.

Clearly, a majority of the long-term care can be self-administered. But they must have the information, they must have access to the right and the best information in order to do well and to prosper healthwise after making the intervention with the health care provider.

We cannot get away from having some type of individualized care. We cannot wholesale all health care. Human beings are different. They react to medications differently. They do better under various different circumstances. That has to be taken into consideration.

When we get to the point where absolutely no individualized opportunities

are there for patients, then we have gotten away from the real meaning of having health care and really even having specialists.

We have come to a point where we must allow a physician to practice medicine. Physicians are trained. They are educated. They must be allowed to practice medicine.

Insurance companies simply cannot practice medicine for that physician. They must be given the leeway of practice so that they can look at that patient and determine what is best for that patient. We have gotten a little bit away from much of that.

I have had numerous visits from hospital staff, from physicians themselves asking for that right to have the opportunity to simply practice their art. That is what they are educated for. They have the expertise.

No insurance company can make that determination for individual patients. Sure we can have broad categories, but physicians must retain their right to practice.

Mr. PALLONE. If I could interrupt the gentlewoman from Texas again, we had a perfect example of this, of course, with the drive-through deliveries for pregnant moms, where it had gotten to the point where many of the women, when they went to the hospital, actually had to leave within 24 hours.

It did not matter whether or not the physician thought that was appropriate or whether the women felt that it was not appropriate, the health insurance company said that is it. She is there for 24 hours. I think it was 2 days for C-section. Again, I think that was a perfect example.

Ms. EDDIE BERNICE JOHNSON of Texas. And for mastectomies.

Mr. PALLONE. Exactly. It has got to be that that decision is made by the doctor with the patient, not by the insurance company. Unfortunately, that is getting to be the case with so many different types of care, not only mastectomies and child birth, but so many of the situations.

Ms. EDDIE BERNICE JOHNSON of Texas. That is why it is so important that we consider legislation now, because it gets to be rather unmanageable to have to bring every particular ailment before this Congress to legislate for that particular ailment.

We need a systemic type of approach. Unless we have an overall general approach as we get the outcry from our constituents around the country, we will be piecemealing it. Every year, we will put something else to be covered by an insurance company or how it is to be covered. That also is not a wise way to do the reforms for our health care system.

We need a more organized, a more intellectualized way of approaching these problems. But if we fail to do that, we will have to continue to look at mastectomies one year, childbirth the next year, prostate surgery the next year, and something else the next year. That is not the appropriate way to address problems.

Mr. PALLONE. One of the areas that concerns me the most in this regard is emergency care, because what I find increasingly is that the people are denied emergency care in the emergency room, or they are allowed into the emergency room, and they are provided care, and, later, the health insurance company does not cover it because they say it was not necessary; it was not an emergency.

So one of the things I think is really crucial is this sort of prudent layperson standard; in other words, that you have to be provided and you have to cover the emergency care if a rational or reasonable person would think that that was an emergency, again, a decision based on what a doctor would think or what the average patient would think, not what the insurance company would think.

Because I am getting more and more cases where, as I said, either people have been denied emergency care or they simply do not cover it, and they send them the bill on their own, which they cannot afford, which, as we know, emergency room care can be exorbitant if we are paying for it privately.

Ms. EDDIE BERNICE JOHNSON of Texas. That is correct. If someone gets ill in traffic on their way home from work, and they happen to stop by an HMO, I had a constituent that this happened to just recently, 15 minutes before it is to close, and be told to come back the next day because they are getting ready to leave. The person has to go to the emergency room, and he ends up being hospitalized. Then that is a situation that can only be governed by a change of attitude where the attitude is toward the care of that patient rather than watching the clock for an employee making a decision at the door before a physician is even seen.

This is when the system is out of control. When the price tag goes up, the cost emotionally and physically to the patient is greater because the employees say it is 15 minutes before it is time for us to get off, and we simply cannot take care of it today. I do not want to be here overtime.

Mr. PALLONE. One of the things that the gentlewoman has really brought out, and I think is so important, is that the emphasis, again, has to be on the quality of care and not so much on the cost of it. We understand that managed care reform has brought great cost savings, but the bottom line is that now it is just out of hand.

If we implemented these patient protections that we are talking about, the cost really is very minimal. I know that that is an argument that is used that, oh, this is going to increase costs, but I do not believe it when we are looking at the kind of common sense approaches that we are talking about here that there is any significant cost increase.

It seems to me, in the long run, we will probably save money, because a lot of it is preventative, and we end up helping people so they do not get sicker.

Ms. EDDIE BERNICE JOHNSON of Texas. One of the fallacies of a system that has failed us is distrust, one of the outcomes. Once the patients distrust a system, the cost of it generally goes up, because there are more complaints, more anxieties, more concerns, and not confident that the quality of care will be there.

Mr. PALLONE. If I could give the gentlewoman an example, just an example of this, when my wife and I had our son 2 years ago, they had just implemented this policy with the pregnant women that they were only allowed the 2 days for a C-section, because he was born with a C-section. She had a C-section.

As they were about to release him from the hospital for the 2 days, they had a pediatrician that was required, I think under the law, had to come in and look at him before he was checked out. They found that he was jaundiced. So they let him stay an extra day. They let her stay an extra day.

If that had not happened and had not been detected, he could have easily gone out of the hospital, gotten worse with the jaundice, end up having to come back to the hospital and stayed a week or more, which would, of course, cost more money.

So, to me, a lot of this is just preventative and actually saves the system money in the long run.

Ms. EDDIE BERNICE JOHNSON of Texas. Oh, indeed. Most obstetricians will tell us that depression and anxiety after childbirth, especially for the first child, is very common. If that mother is forced to leave the hospital while they are still in a real state of uncertainty and not confident whether they know exactly what to do, they are more likely to exaggerate and exacerbate those symptoms than to have their anxieties alleviated.

Clearly, just 24 hours, which we saw the need to correct in the last Congress, is not enough to ensure that that anxiety will not cause unnecessary bleeding and lots of other symptoms that might occur.

When we insist upon these very hard decisions, notwithstanding what that individual reaction might be, then the system has gotten away from the human part of it. That is a major part of healing. That is a major part of well-being with anyone who has a physical symptom.

It seems to me that, under the current system, without correction, we have just said it does not matter. It really does not matter. As long as we stay within the guidelines of this insurance company, that is all that matters.

I do not believe this country is ready for a system that does not care. I think that is why the outcry is now. It is not that people do not respect and do not feel the need for some type of reform.

□ 1930

It is just that when that reform becomes so calculating, so antihuman that it becomes then a failed system. That is why we have the outcry now.

It does not take a lot of big government to correct it. It really takes a very few simple steps to do it that will not be costly. As a matter of fact, I think the costs will be greater to ignore the demands of our general public.

This approach is not partisan. It is really not going to be solved based upon any hard-core decisions. It is going to be solved with us recognizing that patients across this country from all income levels, all walks of life, are rejecting what their experiences are now. I believe we restore the confidence and restore some quality that patients deserve when we can address this through this simple, what we call the patient's Bill of Rights.

It is really not asking a lot. It certainly does not bring in a big government arm to direct everyone around, but it does return some reason. It does return some rights to the patient, that they can feel confident that they have just a little bit of say about what happens to them when they are ill.

It is not a free system. It as a matter of fact, it costs more for the patients to get less. And that will not change with what we are talking about doing. That clearly will not change. But what can change is to have a little better opportunity for a little bit more quality in that care.

Mr. PALLONE. I appreciate the gentlewoman's comments. I think it is absolutely to the point.

I guess I started out today by saying that I really think that we know what has to be done here now. We have talked about this, and the President came forward with a Bill of Rights. Some of the Republicans have sponsored legislation. As we mentioned before, our Democratic health care task force has put forth a set of principles which are going to be put forward in a managed care consumer protection bill that will be introduced very shortly that we are going to be talking about and that we believe we have support for amongst the Senators as well as the White House in favor of this legislation.

But what really needs to be done is, we need to push the Republican leadership to bring this managed care reform to the floor of the House, to bring it up in the relevant committees, to push that it come to the floor of the House, and do the same in the Senate.

We do not have a lot of time here between now and the end of this legislative year. If we do not act quickly, and after all the Republicans are in charge of the process, they are in the majority; they are the ones that are going to decide what can come to the floor. If they do not bring this up and allow for debate and allow for a vote, then it is not going to happen.

Part of the reason why we, as Democrats, constantly talk about this and will continue to talk about it is because we know that we need to push them to bring it up. Otherwise, it is not going to happen this year.

Ms. EDDIE BERNICE JOHNSON of Texas. Mr. Speaker, I thank the gentleman for his leadership. I hope that we can depend on our Republican leadership to be responsive to the voices of the American people.

It is not just Democrats that we are hearing from. My district has as many Republican voices speaking out and asking for some type of redress as do Democrats. It is an issue that all Americans have concern about, especially those working Americans who cannot actually pay for the cost of health insurance in an independent plan.

We know we have to have these larger, supposedly affordable plans. But these plans do not work with gag orders. These plans are not working with all of the restrictions. Patients need a little bit more freedom of choice, and they need to feel confident that there is a little that they can expect coming to them after paying into these plans.

I do not believe it is asking too much. I think the profits for the insurance companies would still be good, because in the long run it would reduce cost; it would reduce cost because you reduce anxiety, you reduce skepticism and you restore some confidence that when care is needed, care will be there.

Once we restore some of that confidence, remove the gag orders so they will know the full truth, then I believe that we will certainly continue to control that cost. Otherwise, we have a system that is considered to be broken. And just because we ignore those voices does not mean they are going away. They will continue to speak out.

I think we have a duty and a responsibility to be responsive to those voices. I thank the gentleman for his leadership.

Mr. PALLONE. I thank my colleague from Texas also for joining me, and for her insight into this as a nurse, as well, because it is often those who are involved in the health care system as nurses, physicians, they are the ones that have the most knowledge and understand the kind of problems that many patients now face with the existing managed care or HMO systems.

I was going to ask my colleague, if I could indulge the Speaker tonight, I began this evening by going through the testimony of a New Jerseyan, Cheryl Bolinger, who had experienced some severe problems dealing with the managed care system with her daughter. I did not complete her statement. I know that there is not enough time in the time that is allotted to us to complete it. I would like to either include it in the record now, if I could; or if not, I will put it in as an extension of remarks this evening because she really outlines very well the kinds of problems that a mother or somebody goes through when they are trying to get through this sort of Byzantine labyrinth of managed care.

I just cannot imagine myself, if it was my daughter or my son, to have to go through this experience to get the proper care and to make the appeals and to deal with the objections and follow a grievance procedure. She was spending, from what I can see, more time doing this than she was with her job. She was not a woman who was in a position to be able to spend the time from 9:00 to 5:00 taking appeals of decisions that were made by HMOs.

So many people face this on a regular basis. Fortunately, her daughter had a mother who had the willingness and aggressiveness and understanding about what to do, but many people do not. That is the problem. That is why we need our legislation.

Ms. EDDIE BERNICE JOHNSON of Texas. Let me just quickly say that I am from Texas. It is not known to be a liberal State. As a matter of fact, we are kind of known to be a rather stubborn State. But one of the Republican leaders in the State Senate introduced and passed a bill to allow for HMOs to be sued.

We have had a real fiasco in our State in how they have been able to function and the kind of quality that has virtually disappeared in health care.

This was not brought forth by a liberal spending person. It was brought to the legislature by a very conservative Republican, because we have had probably one of the most unpleasant experiences in our State in dealing with our HMOs. We have had a number of, just a burgeoning number of complaints with them virtually having no way to do anything about it. I know this is not just my State. I believe this is happening around the country. I think that we have the responsibility to address these issues for the American people.

During the district work period week of February 20, President Clinton issued an executive order directing all federal health plans, which serve over 85 million Americans, to come into compliance with his quality commission's consumer bill of rights. At the same time, many constituents asked me when Congress would follow the President's example and pass legislation that assures that the initiatives in his executive order for the patients' bill of rights becomes standard for all Americans.

Four weeks later, I still have to inform my constituents that the majority has not scheduled a vote on such an important matter.

As a member of the democratic health care task force, I look forward to the challenge of ensuring that more than 160 million Americans in managed care plans get the quality care they deserve, with more choices, protections and freedoms.

Some special interests wish to label reform efforts as more big government. Giving more choices and quality care to more consumers in not big government, it is a ''patients bill of rights'' that has people and their well-being in mind.

One example of the problems Americans experience with managed care is illustrated by a Kaiser Family/Harvard University poll which

found that three-fifths of Americans feel managed care has resulted in doctors spending less time with patients.

Americans are clear on the need for managed care reform. Congress should be clear on their commitment to enact it. The American people leave no doubt about their displeasure with health plans because of cost considerations and withholding important information from patients because of "gag orders."

As a lawmaker, registered nurse and businesswoman, I know the benefits of not only protecting patients, but also giving them choices. Protecting patients and giving them choices are good policy, good health care and good business.

This year, I will work to ensure that Congress answers the calls from Americans who are dissatisfied with their health care plans. It is important that Members of Congress from both parties work to provide Americans with a basic "patients bill of rights."

I ask that the leadership in Congress answer the President's call, but more importantly, the American people's call to pass a "patients bill of rights this year."

If we do not act now, we are faced with the reality that millions of Americans in private health plans may never be assured that they will also have the protections that their counterparts in federal plans enjoy.

I yield the balance of my time.

Mr. PALLONE. Mr. Speaker, it is important for us to tell these stories because I think that it is only when we tell the stories of our constituents and the people that have been through the system and the public and the other colleagues down here understand what our constituents are going through that we will get a ground-swell of support for managed care reform. I think it is very important that we relate those stories.

I want to thank my colleague again.

Mr. Speaker, I include for the RECORD the testimony to which I referred:

TESTIMONY OF CHERYL BOLINGER

January 22, 1998.

Good morning Senator Torricelli and Congressman Pallone. Thank you for your interest in hearing about the struggles my family has had in trying to receive good, quality medical care from an HMO for our daughter.

My name is Cheryl Bolinger and I am the mother of a 15-year old child who has multiple developmental disabilities and complex, chronic medical problems. My daughter Kristin's medical problems began shortly after her birth. At six weeks of age, she developed unexplained intractable seizures. Because of the severity and the debilitating effects of her condition, she must be followed by many specialists and undergo many specialized and expensive diagnostic tests.

Today, Kristin remains non-verbal and non-ambulatory, and requires customized durable medical equipment for every aspect of daily living. Customized equipment is also needed to prevent and minimize the effects of orthopedic problems. She also requires physical and occupational therapy to enhance and maximize her potential in terms of her orthopedic status and general medical condition.

During Kristin's infancy and early childhood, we were fortunate enough to have a free-for-service insurance plan. As long as our medical documentation was current and in place, (i.e., prescriptions, follow-up care, and letters of medical necessity), we did not encounter problems obtaining adequate and proper medical care regarding all areas of our daughter's acute and long-term care.

In 1993, however, our insurance plan was changed to an HMO. At that point, we encountered many difficulties regarding Kristin's medical care. According to the plan, we had to choose a pediatrician who had contracted with the HMO to serve as her primary care physician. The pediatrician who had been seeing Kristin for many years was not a participant in the plan. Likewise, the specialists who had been treating her for so long also were not plan participants. My husband and I were very upset over this change and need to give up the excellent care Kristin had been receiving from these physicians. We were very concerned about the future of our child's health care.

Nevertheless, we tried to be optimistic and we visited a plan-approved pediatrician who would serve as Kristin's primary-care physician. To our dismay and disappointment, we were not satisfied with the level and quality of care provided. Our freedom to choose a suitable physician for our child while receiving adequate insurance coverage had been taken away by the HMO.

After such a disheartening experience, we decided that it would be in Kristin's best interest to remain with her current pediatrician and specialists. They were the doctors who knew her best. As a result of our decision, our benefits were reduced and we were required to pay out of pocket.

Also in 1993, we were advised by our insurance company's medical review board that it had deemed Kristin's therapies to be not medically necessary. Even though medical documentation recommending these therapies was in place, benefits were ceased. Because of the importance and necessity of therapies for our child, we paid for them out of pocket.

In 1994, Kristin developed a scoliosis curve which required bracing. We used an orthotist in our HMO plan to manufacture the brace. When I returned to our orthopedist with the brace, he told me it was worthless and would probably increase the curvature rather than inhibit it. My doctor was irate that the HMO had contracted with a company that provided substandard equipment; he referred us to an orthotist of his choice who manufactured the brace free of charge.

I called and wrote to my HMO regarding the inferior quality of the brace the orthotist in their plan had made for us. They responded by telling me they wouldn't handle the problem and to contact the agency they contract with. I phoned and sent written correspondence to the agency regarding the problem. However, other than someone saying they would make a note of the situation, I never received a satisfactory answer or explanation regarding the inadequate and inferior quality of the brace.

In August 1997, Kristin underwent scoliosis surgery, which required spinal fusion and instrumentation—a complicated and serious surgical procedure. Fortunately, we were able to use a reputable prominent surgeon in New York City who was on our plan as a participating specialist. At this time, Kristin's post-operative condition was very fragile. Upon discharge from the hospital, Kristin was to receive nursing care and physical therapy at home. The surgeon wrote very specific orders regarding the medical care and rehabilitation needed at home.

After Kristin had been home for nine days, I received a phone call from the contracted nursing agency informing me that nursing services would no longer be covered and were to cease. Contrary to our surgeon's recommendations, the HMO opted to provide a home health aide instead of a nurse to care for Kristin's nursing needs. The level and quality of care provided by a home health aide was not adequate for my daughter's complex medical needs. I immediately became actively involved in requesting that the HMO cover the necessary nursing care. After several additional letters of medical justification, repeated taxes, phone calls, and communication, the HMO conceded that they should follow the initial recommendations of their surgeon. Nursing care was reinstated after seven days.

The surgeon also wrote very specific instructions regarding special therapy for rehabilitation. Physical therapy was ordered for 12 weeks. However, after only about six weeks—half the period recommended by the surgeon—I received another phone call from the contracted agency stating that physical therapy would no longer be covered and would cease. Once again after my repeated attempts to correct the situation, the insurance company reinstated therapy after a two-week lapse. In both situations, continuity of vital services for my daughter was interrupted due to poor decisions made by the HMO.

On our most recent follow-up visit to the surgeon (January 14, 1998) he was not satisfied with Kristin's post-operative rehabilitation. He requested Kristin receive additional physical therapy so that she could regain her post-operative abilities and level of functioning. To date, I am still awaiting a response to this request from the HMO.

Because of surgery and the changes in Kristin's body alignment, a new wheelchair is needed to accommodate her post-operative status. We have been waiting for three-and-a-half months for secondary approval of this crucial and essential piece of equipment and have still not received a decision from the HMO. In the meantime, we have no choice but to keep our daughter in a wheelchair that no longer meets her needs while we continue to wait for a response.

In conclusion, I would like to state that HMO's present the following problems to families trying to obtain health care for a family member who has developmental disabilities and requires long-term care.

Freedom to choose qualified physicians is compromised.

The quality, continuity, and duration of care is subjected and often does not meet the medical need of the patient.

Durable medical equipment that must be customized and is not a stock item is often inadequate and inappropriate for specific medical needs.

Many crucial requests are denied or delayed for too long a time.

The time and effort our family invests in trying to correct the poor judgement of our HMO and the stress this creates takes away from the valuable time we need to care for our child. Unfortunately, this is the constant battle we must wage to try to obtain proper, quality care for our daughter.

Thank you very much Senator Torricelli and Congressman Pallone for listening to the problems I have had in obtaining good quality medical care for my daughter, Kristin.

AN AMERICAN DREAM

The SPEAKER pro tempore (Mr. JONES). Under the Speaker's announced policy of January 7, 1997, the gentleman from Wisconsin (Mr. NEUMANN) is recognized for 60 minutes as the designee of the majority leader.

Mr. NEUMANN. Mr. Speaker, I rise tonight to talk about this great Nation we live in. I was reminded over the weekend just what a great country it